

# GRIFFITH REHABILITATION HOSPITAL

## PRE ADMISSION REFERRAL FORM

**FAX TO: Rehabilitation Co-ordinators  
(08) 8377 0543**

Affix sticky label here if available.

**NAME:** \_\_\_\_\_

**HOSPITAL:** \_\_\_\_\_

**WARD:** \_\_\_\_\_

**ADMITTING DIAGNOSIS:** \_\_\_\_\_

**EXPECTED TRANSFER DATE:** \_\_\_\_\_

**REQUESTED PRE-ADMISSION  
ASSESSMENT DATE:** \_\_\_\_\_

Accepted  Date of Transfer: .....

Rejected  Reason .....

.....

**SIGNATURE:** \_\_\_\_\_

**DATE:** \_\_\_\_\_

**Rehabilitation Co-ordinators, Denise Collopy, Lauri Wild or Julie Vincent will assess patients within 24 hours of referral, unless otherwise indicated.**